Billers' Association for Long-Term Care

Policy and procedure: Medicare Part A triple-check process

Purpose:

The purpose of the form is to ensure that Medicare is billed accurately and in a timely manner for all allowable incurred costs the facility has acquired under the Medicare program.

Directions:

See procedure which precedes form.

Should be completed by:

See identified areas listed on next pages.

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Policy: The objective of the policy is to ensure that Medicare is billed accurately and in a timely manner for all allowable incurred costs the facility has acquired under the Medicare program.

Procedure: The facility will be responsible for implementing monthly the Medicare triple-check process to verify that claims are accurate prior to submission to the MAC. The facility each month will verify all Medicare claims prior to submission. The Medicare triple-check process will be completed by the following individuals: administrator, director of nursing, MDS coordinator, facility rehab director or designee, business office manager, medical records, and central supply. The Medicare triple-check process will ascertain and document key items for each Medicare claim using the Medicare triple-check audit tool.

In order to ensure that the Medicare triple-check meeting is completed in a timely manner, each of the facility participants will complete each of their respective key items in advance of the meeting. The meeting is not a working meeting to complete the information. The Medicare triple-check meeting is for verification and cross-check review of the Medicare claim by the interdisciplinary team. Verification and cross-check means that the key items should be verified by a member of the team other than those responsible for completing the information.

The Medicare triple-check audit tool will be completed by the business office manager during the triple-check meeting and filed within the month-end closing reports. Items that have been verified as correct will be noted with an "X." Items that have been identified as incorrect shall be noted with an "O," and necessary steps to obtain the correct information should be noted in the remarks section. Incorrect items that are corrected immediately during the meeting should be marked with an "O" in order to accurately reflect the communication and processes within the facility and assist in identifying additional training needs. Medicare claims identified with errors during the triple-check will be put on hold and will not be transmitted to the FI or MAC until the claim is corrected. Once the incorrect item has been corrected, the business office manager will indicate the correction and date in the remarks section of the Medicare triple-check audit tool that contained the error. The business office manager will then contact the corporate designee to review corrections and get approval to submit the claim to the FI or MAC.

Business office manager & medical records:

1. Verify qualifying stay on UB-04 to medical records face sheet

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Business office manager:

1. Verify that resident has benefit days available per the CWF (HETS).
2. Verify admit date on UB-04 agrees to manual census log.
3. Verify covered service dates on UB-04 agree to Medicare log and manual census log.
4. Verify that there is a signed and completed MSP form in patient's financial file.

Business office manager & MDS coordinator:

1. Verify ADLs are correct and supported by documentation and other contributory items are coded (e.g., mood, IVs, etc.).
2. Verify that each of the MDS used in following checks agrees to validation report received from the state repository.
3. Verify that assessment reference dates per each MDS agrees to UB-04 FL 45.
4. Verify that RUG level per each MDS agrees to UB-04 FL 44.
5. Verify that assessment type for each MDS agrees to modifier on UB-04 FL 44.
6. Verify that number of accommodation units on UB-04 agree to assessment type for each MDS. Verify that total number of accommodation units agrees to covered service dates.

Facility rehab director, MDS coordinator & business office manager:

1. Verify that physical therapy minutes per the daily treatment grid agree to service log. Agree days and minutes per the MDS to the treatment grid. Agree number of units billed on the UB-04 to the service log.
2. Verify principle diagnosis is accurate, secondary diagnoses all support skilled care, and the ICD-9 (ICD-10) codes correspond to the diagnoses.
3. Verify that occupational therapy minutes per the daily treatment grid agree to service log. Agree days and minutes per the MDS to the treatment grid. Agree number of units billed on the UB-04 to the service log.
4. Verify that speech therapy minutes per the daily treatment grid agree to service log. Agree days and minutes per the MDS to the treatment grid. Agree number of units billed on the UB-04 to the service log.

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Director of nursing & medical records:

1. Verify that resident required Medicare skilled intervention through supporting clinical documentation during dates of service per the manual census log
2. Verify that physician certification/recertification form has been completed and signed by physician
3. Verify that physician orders have been obtained and implemented
4. Verify that charting guidelines are in the chart, charting is completed at least one time in every 24-hour period, charting relates to the skilled service being provided, charting supports therapy services

Facility rehab director:

1. Verify that rehabilitation services are stated on physician orders
2. Verify that evaluation includes prior level of function
3. Verify that clinical documentation states progress noted warranting continued skilled intervention

Administrator:

1. The role of the administrator is to chair the triple-check meeting and ensure that the process is completed by the facility each month prior Medicare claims submitted to the MAC. Participation in the Medicare triple-check will allow the administrator to monitor communication effectiveness of facility processes between the interdisciplinary team.